



## Apache Drive Children's Clinic

### NEW PATIENT QUESTIONNAIRE:

**PATIENT NAME:** \_\_\_\_\_

**PATIENT DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

- 1) **PLEASE NAME YOUR CHILD'S PREVIOUS PCP:** \_\_\_\_\_
- 2) **WHAT IS YOUR REASON FOR LOOKING/NEEDING A NEW PCP?**  
\_\_\_\_\_  
\_\_\_\_\_
- 3) **IN THE LAST YEAR, HOW MANY TIMES HAS YOUR CHILD VISITED AN URGENT CARE/ER FOR CARE?**  
  
A) 0-1                      C) 5-6  
B) 2-4                      D) 8 OR MORE
- 4) **HAS YOUR CHILD EVER BEEN DISCHARGED FROM ANY MEDICAL PROVIDER IN THE PAST? PLEASE LIST THE REASON FOR DISCHARGE IF YOU ANSWER YES.**  
YES    OR    NO    \_\_\_\_\_
- 5) **DOES YOUR CHILD RECEIVE CHILDHOOD VACCINATIONS? IF YOU ANSWER YES, ARE THEY UP TO DATE ON THEIR VACCINATIONS? IF YOU ANSWER NO, PLEASE PROVIDE A REASON THAT THEY ARE NOT RECEIVING VACCINATIONS.**  
YES    OR    NO    \_\_\_\_\_
- 6) **HAS YOUR CHILD BEEN DIAGNOSED WITH AUTISM, ADHD, ANXIETY/DEPRESSION?**  
YES    OR    NO
- 7) **IF YOU ANSWER YES TO QUESTION 6, PLEASE LIST ANY MEDICATIONS THAT THEY TAKE FOR THESE CONDITIONS?** \_\_\_\_\_
- 8) **IF NOT ON ANY MEDICATIONS FOR THE ABOVE CONDITIONS, DO YOU PLAN TO DISCUSS STARTING MEDICATION AT YOUR INITIAL NEW PATIENT VISIT? YES OR NO**

APACHE DRIVE CHILDREN'S CLINIC  
Patient Registration

**Patient:** Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Sex: Male or Female DOB: \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_\_\_

Primary Language: \_\_\_\_\_ Secondary Language: \_\_\_\_\_

Ethnicity: Hispanic/ Non-Hispanic/ Unknown/ Decline to Specify

Race: Asian/ American Indian-Alaskan/ African American/ Pacific Islander/ White/  
Middle East/ Other/ Decline to Specify.

School or Daycare: \_\_\_\_\_

**Home Address:**

\_\_\_\_\_ ( Street) (City) (State & Zip)

If you also have a PO Box ( Include zip code)

**Emergency Contact: ( other than parents):**

\_\_\_\_\_ Name and Relationship to Child Phone Number

**Parent 1 or Guardian:** \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Lives with patient: Yes / No If No, Address \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Social Security Number: \_\_\_-\_\_\_-\_\_\_

Home Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Cell Phone:(\_\_\_\_)-\_\_\_\_-\_\_\_\_ Carrier ( \_\_\_\_\_ )

Email: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone Number: (\_\_\_\_)-\_\_\_\_-\_\_\_\_

**Parent 2 or Guardian:** \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Lives with patient: Yes / No If No, Address \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Social Security Number: \_\_\_-\_\_\_-\_\_\_

Home Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Cell Phone:(\_\_\_\_)-\_\_\_\_-\_\_\_\_ Carrier ( \_\_\_\_\_ )

Email: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone Number: (\_\_\_\_)-\_\_\_\_-\_\_\_\_

If Parents are divorced or separate please fill out this section:

Who has custody of the patient?( please include relationship):  
\_\_\_\_\_

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? YES / NO

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.  
\_\_\_\_\_

**INSURANCE:**

Insurance Carrier: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_  
Policy Holder's Gender: Male / Female  
Policy Holder's relation to patient: \_\_\_\_\_  
Policy Holder's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Policy Holder's Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Insurance ID Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_

**PRIVACY/HIPAA:**

The State of Arkansas recognizes the genetic mother and father to hold the rights of medical disclosure until the age of 18, this form is for extending disclosure rights to other parties.

I AUTHORIZE APACHE DRIVE CHILDREN'S CLINIC TO DISCLOSE PERSONAL HEALTH INFORMATION TO THE FOLLOWING:

NAME:

RELATIONSHIP TO PATIENT:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

# MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

Place of Birth \_\_\_\_\_

Problems during pregnancy? \_\_\_\_\_

Type of Delivery: Vaginal \_\_\_\_\_ C/Section: repeat \_\_\_\_\_ emergency \_\_\_\_\_

Problems during Delivery: \_\_\_\_\_

Significant problems during newborn period (1st 2 weeks): \_\_\_\_\_

Has this child ever received a blood transfusion of any blood products? YES NO

IS THIS CHILD CURRENTLY TAKING ANY MEDICATION? YES NO. if yes please list:

\_\_\_\_\_

Has this child had any immunizations? \_\_\_\_\_ if yes, are they up to date? \_\_\_\_\_

IF CHILD IS AN INFANT:

Breast feeding \_\_\_\_\_ Formula Feeding \_\_\_\_\_ if so which formula? \_\_\_\_\_

Do you feel your baby is developing normally? \_\_\_\_\_ if NO what are your concerns? \_\_\_\_\_

IF YOUR CHILD IS OF SCHOOL AGE:

How is your child doing in school? \_\_\_\_\_

Where does he attend school? \_\_\_\_\_ Current Grade \_\_\_\_\_

Are there any significant behavioral or emotional problems in your opinion? \_\_\_\_\_

if your child is over 10 years of age, did they received their 2nd MMR? YES NO

IF PATIENT IS FEMALE ADOLESCENT:

is she having periods yet? \_\_\_\_\_ How old was she at menarche (first period)? \_\_\_\_\_

Periods are: \_\_\_\_\_ Regular \_\_\_\_\_ Irregular FLOW: \_\_\_\_\_ Heavy \_\_\_\_\_ Normal \_\_\_\_\_ Light

**PATIENTS MEDICAL HISTORY:**

MONTH / YEAR	PAST MEDICAL PROBLEMS	MONTH / YEAR	SURGERIES

Does this patient have any known allergies? YES NO

if yes please specify: MEDICATIONS \_\_\_\_\_ OTHER \_\_\_\_\_

Mother's Health \_\_\_\_\_ Health Problems \_\_\_\_\_

Father's Health \_\_\_\_\_ Health Problems \_\_\_\_\_

**HEALTH HISTORY OF BROTHERS / SISTERS:**

Name of Brother or Sister	Age	M	F	Health—include past/present Problems

DOES OR HAS ANY BLOOD RELATIVE OF THIS CHILD HAVE OR HAD ANY OF THE FOLLOWING? :

- \_\_\_ Diabetes \_\_\_ Cancer \_\_\_ Bleeding Disorder \_\_\_ Anemia \_\_\_ Kidney Disease \_\_\_ Tuberculosis
- \_\_\_ Heart Disease \_\_\_ Stroke \_\_\_ High Cholesterol \_\_\_ High Blood Pressure \_\_\_ Arthritis \_\_\_ Lupus
- \_\_\_ Rheumatic fever \_\_\_ Asthma \_\_\_ Psychiatric Disorder \_\_\_ Crohns/Ulcerative Colitis
- \_\_\_ Cystic Fibrosis \_\_\_ Seizures/Epilepsy \_\_\_ Hearing Impaired \_\_\_ Vision Impaired



# Apache Drive Children's Clinic

Apache Drive Children's Clinic  
3203 Methodist Drive Jonesboro, AR 72401  
Phone: 870-935-1800 Fax: 870-935-2917

## AUTHORIZATION OF RELEASE OF CONFIDENTIAL INFORMATION:

Internal Note: An original authorization shall be signed for each request of release of information.

To/From: Apache Drive Children's Clinic  
3203 Methodist Drive  
Jonesboro, AR 72401

To/From: \_\_\_\_\_  
Address: \_\_\_\_\_

Contact: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

I, \_\_\_\_\_, Parent/Guardian of the patient named below, give ADCC permission to obtain from or give to the above named agency/person, pertinent social, medical, other information listed below. I understand that this information is confidential and will only be used for the benefit of the patient. I understand that this information may be subject to re-release by the recipient without the knowledge or consent of ADCC and that ADCC is in no way responsible for this action.

### DOCUMENTS TO BE RELEASED:

- |          |          |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

### PURPOSE FOR RELEASE (CHECK ALL THAT APPLY):

\_\_\_\_ At the request of patient or parent/guardian

\_\_\_\_ Per ADCC discretion or needs

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Parent/ Guardian: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

ARKANSAS MEDICAID PRIMARY CARE PHYSICIAN MANAGED CARE PROGRAM  
PRIMARY CARE PHYSICIAN SELECTION AND CHANGE FORM

Member Information:

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Medicaid ID# \_\_\_\_\_ Social Security # \_\_\_\_\_  
Birth Date (mm/dd/yyyy) \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email address \_\_\_\_\_

Requested New Doctor (Primary Care Provider):

I have picked the three (3) physicians named below in order of my preference to be my primary care physician. I understand only one (1) of them will be my primary care physician.

- |    |                                                          |                                           |                             |
|----|----------------------------------------------------------|-------------------------------------------|-----------------------------|
| 1. | <u>MARVIN LOWERY BECK</u><br>Doctors first and last name | <u>119050001</u><br>Medicaid Provider ID# | _____<br>Date of assignment |
| 2. | _____<br>Doctors first and last name                     | _____<br>Medicaid Provider ID#            | _____<br>Date of assignment |
| 3. | _____<br>Doctors first and last name                     | _____<br>Medicaid Provider ID#            | _____<br>Date of assignment |

Reason for Request to Assign/Change Doctor (Primary Care Provider)  
Choose all that apply. Select at least one.

- New Member - made 1<sup>st</sup> time selection
- Already patient with requested PCP
- Requested PCP already sees family member
- Member preference
- Member moved
- PCP hours didn't fit member need
- Quality of care
- Office wait times are too long
- Takes too long to get an appointment
- Office too far away/ hard to get to
- Language / communication barrier
- Other (please specify) \_\_\_\_\_

Signatures:

Member Signature (or Legal Guardian if a minor) \_\_\_\_\_  
Printed Name of Member (or Legal Guardian if a minor) \_\_\_\_\_  
Date (mm/dd/yyyy) \_\_\_\_\_



**NO SHOW POLICY:**

**LOWERY BECK, M.D.**

**SASHA CLEMENTS, APRN**

Quality care for our patients is our top priority. Please take a few minutes to read our No-Show Policy and sign it at the bottom. If you have any questions related to this policy, please let one of our staff know.

Our goal is to provide the best possible care for each of our patients and do so in a timely manner. Therefore, to make that possible, Apache Drive Children's Clinic has implemented a No-Show/Cancellation Policy.

We define a No Show as any patient who fails to show up for their appointment, fails to cancel their appointment at least 2 hours prior to their appointment time, or those who show up their appointment more than 10 minutes late, thus not being able to be seen. Our 10-minute grace period for appointments is not guaranteed. We reserve the right not to see your child if you are past your scheduled appointment time.

After 2 No Show appointments, a patient may receive a letter in the mail notifying them of their previously missed appointments. Once the patient misses a 3rd appointment, he/she may be discharged from our practice. We understand that sometimes you simply cannot make it to your appointment. All we ask is that you respect our time and our other patients' time and call to cancel or reschedule your appointment. We appreciate your cooperation in this matter and look forward to providing your child with the best healthcare possible.

Patient Name: \_\_\_\_\_

Parent Signature and Date: \_\_\_\_\_



## **ER/URGENT CARE POLICY:**

**LOWERY BECK, M.D.**

**SASHA CLEMENTS, APRN**

Our practice values the opportunity that we have to treat your child for all their healthcare needs. We realize that at times it may be necessary to take your child to see another healthcare provider such as an Urgent Care or ER. However, our providers ask that you keep that to a minimum and only do so if instructed to by our staff or on-call service.

Reasons to visit an ER should be due to a true emergency. This would include things such as a broken bone, if your child was involved in a car accident, if they are having trouble breathing, if they need stitches and our office is closed, a fever of 105 or greater that you cannot get under control, etc. Urgent Care should not be used unless our staff or on call service advises you to take your child. We ask that you bring your child to see one of our providers above, taking them anywhere else.

Our practice offers a walk-in-sick call Monday-Friday from 7:30am-9:00am (No appointment is needed during this time). We also offer same day appointments and appointments until 4:30pm Monday-Friday. Our practice offers after-hours care as well. You can call our main number, 870-935-1800, after 5:00pm and you will be directed to a nurse at Arkansas Children's Hospital that can give you medical advice on your child.

Our practice monitors our patient's use of the ER and Urgent Cares. We receive reports about when a patient of ours is seen at another healthcare facility and the reason for the visit. If you utilize other healthcare settings for non-emergent reasons, or without being instructed to do so, you will receive a warning letter in the mail. If you continue to use the ER or Urgent Cares after a warning letter has been mailed out to you, your child will be discharged from our practice.

**Patient Name:** \_\_\_\_\_

**Parent Signature/Date:** \_\_\_\_\_



## VACCINATION POLICY

LOWERY BECK, M.D.

SASHA CLEMENTS, APRN

Childhood vaccinations are very important in keeping children of all ages safe and healthy. Our practice strongly believes that keeping your child up to date on their vaccinations is important in your child's overall health. We understand that sometimes there are fears and concerns related to vaccines. We are committed to providing you with the most up to date information relating to childhood vaccines so you can make an informed decision when it comes to your child.

Our providers believe that vaccinations work to prevent preventable communicable diseases like Measles, Mumps, and Polio. They believe that vaccinations are essential in keeping our community and each other safe and healthy. For these reasons, our providers require vaccinations to be a patient in our practice. However, we are also sympathetic to the fears and concerns that you may have as a parent regarding vaccines. For this reason, we do allow you the choice to delay vaccines for your child's 1<sup>st</sup> year of life. Our providers offer a catch-up schedule to get your child back on schedule once they turn a year old.

Our providers require anyone who is delaying vaccinations to sign a contract that states that you agree to give your child's vaccinations after they turn 1 year old and that you agree to adhere to our clinic's vaccination catch-up schedule. Failure to keep this contract, keep appointments where vaccinations are given, or any other violation of this policy will result in your child being discharged from our medical practice. This is not an easy decision, and it is not meant to punish anyone for not vaccinating their child, however, it is for the safety and wellbeing of all our patients and staff members. If you have any questions related to this policy, please feel free to speak with one of our staff members.

Patient Name: \_\_\_\_\_

Parent Signature and Date: \_\_\_\_\_



## FINANCIAL POLICY:

Payment in full is expected at the time of service. If an insurance or Arkansas Medicaid policy is effective, only the co-pay/co-insurance is collected. Personal Checks, Cash, Debit Cards, Master and Visa Cards are accepted.

Apache Drive Children's Clinic currently has a participating agreement with Arkansas Medicaid, ARKids First, and the following insurance companies: Blue Cross Blue Shield, USABLE, First Source, Health Advantage, Cigna, United HealthCare, all PASSE Insurances, and many others. We will file an insurance claim with these carriers and the insurance payment will be made to the clinic. If you are unsure if we participate in your plan, please check your benefit manual or contact your insurance company or employer. Our physician is on active staff with NEA Baptist Memorial Hospital. If your insurance plan requires you to use St. Bernard's Medical Center, our physician will not be able to treat you there. Please call your insurance company to verify which hospital is covered. We will file the insurance claim form on all hospital charges.

Medicaid and ARKids First patients are expected to bring their current care on the date of service. If our physician is not the PCP, you will be required to pay for the services provided at the time of check in. If Medicaid shows the coverage as inactive on the date of service, the patient will be responsible for payment of that day's charges. We will not refile claims with AR Medicaid, if the insurance is inactive on the date of service.

Financial Counseling is available with a patient account representative if you need assistance in complying with our financial policy. We will not discontinue services to patients who make appropriate, timely, monthly payments on their accounts. Accounts over 150 days old will be sent to an outside collections agency if payment arrangements have not been made with one of our account representatives. All accounts that are sent to collections will result in dismissal from our practice.

Parents with newborn babies must provide our clinic with proof of insurance by the time the baby is 8 weeks old. If you do not have insurance by that time, you will be asked to pay the full balance on the account and will be required to be self-pay for all visits moving forward until insurance is provided. If you are self-pay for a visit, we will not go back to file those charges to your insurance.

Patient Name: \_\_\_\_\_

Parent Signature and Date: \_\_\_\_\_